**\*ALL FIELDS NEED TO BE COMPLETED\***

**Specialist Prosthetic Referral Form (DSF5/4)**

| **Patient Details (Attach addressograph)**Name:Address:Dob:Hospital number/NHS number:Male/Female (Please Circle)Home telephone number:  | **GP Details:**Name:Address: |
| --- | --- |
| **Next of kin details:**Name:Address:Telephone number: |

|  |  |
| --- | --- |
| **Details of amputation** |  |
| Primary cause of amputation: |  |
| History leading up to amputation: |  |
| Level(s) and right/left: |  |
| Operation dates: |  |
| Details of operation: |  |
| Relevant post-operative details: |  |
| Consultant in charge: |  | Hospital and ward: |  |
| **Contralateral limb details** e.g. circulation, sensation, etc |  |
| **Previous Medical History** e.g. diabetes |  |

|  |  |  |
| --- | --- | --- |
| **Podiatry referral?** (Yes/No) |  |  |
| **Other relevant details** e.g. MRSA status,Latex allergy, Smoking, Alcohol, Other Substances |
|  |
| **Previous Mobility** e.g. independent, stick |
|  |
| **Home environment** e.g. access, stairs |
|  |
| **Current Medications** |
|  |
| **Allergies** |
| **Current wound status**  |  |
| **Physiotherapy details** (current or planned)Name and hospital: |  |
| **Waterlow Score: Date:**  |

|  |
| --- |
| **Has the patient ever served in the armed forces?** **(**Please circle all that apply) YES NO VETERAN WAR PENSIONER |
| **Any further comments:** |
| **Discharge destination:** |  |
| **Details of referrer**Name: Position:Bleep number: Hospital: Signature: Date/Time  |

**Please post or fax the referral form to:**

**Prosthetics Rehabilitation Service, 1 Brest Way, Derriford, Plymouth**

**PL6 5XW.**

**Telephone: 01752 434227**